

## Southeast Chapter of the WOCN® Society Rookie of the Year Award Application

### Nominee Criteria:

- Current active member of the Southeast Chapter of the WOCN Society – (Member of the WOCN Society with SEC selected as your Chapter)
- Engaged in clinical practice of wound, ostomy, continence, or foot care nursing for less than 2 years
- Certified by the WOCNCB® in one of the following: wound, ostomy, continence, and/or foot care
- Endorsed by one or more peers for recognition status
- Current board members are not eligible for this award

All information potentially identifying the nominee will be redacted for an impartial blind vote by the Southeast Chapter Board of Directors.

Date: \_\_\_\_\_

### Information of the Nominee

Email Address: \_\_\_\_\_

First and Last Name: \_\_\_\_\_

City/State: \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_

Is the nominee employed as a WOC Nurse?:    Yes    No

Employer: \_\_\_\_\_

Title or Role: \_\_\_\_\_

Name of nursing school attended (if known): \_\_\_\_\_

WOC nursing school attended (if known): \_\_\_\_\_

Date of Cert and Re-Cert: \_\_\_\_\_

WOCN Member ID Number: \_\_\_\_\_

Southeast Chapter Member:    Yes        No

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**Demonstrates excellence in the practice of WOC nursing by:**

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**Exemplifies high professional standards as evidenced by:**

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**Provides service in the community by:**

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**Promotes pride in the National WOCN Society and the Southeast Chapter of the WOCN Society by:**

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**Demonstrates interest and positive attitude to meet the needs of patients, families, visitors, significant others, industry, co-workers, physicians and association by:**

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**List other achievements:**

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Is the nominee aware of this nomination?    Yes    No

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**Nominator (Your Information)**

Email Address: \_\_\_\_\_

First/Last name: \_\_\_\_\_

City/State: \_\_\_\_\_

Preferred Phone number: \_\_\_\_\_